Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

SAN ANTONIO MEDICAL SUPPLIES
PO BOX 100456
SAN ANTONIO TX 78201

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number:
M4-11-0457-01

MDR Date Received:
OCTOBER 6, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per T.D.I. for Worker's Comp…, (c)(9) preauthorization is required on 'all durable medical equipment (DME) in **excess of $500** billed charges per item (either purchase or expected cumulative rental)'. The billed amount for this item was $393.73. Additionally, determination for payment can also e based on ODG recommendations. [Injured employee's] compensable injury includes Sprain of Knee & Leg NEC (944.8). Per ODG, a TENS unit is recommended for treatment for ICD-9 code 844.8…"

Amount in Dispute: $393.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division adopted Rule §137.100(f) on May 1, 2007 an states ' [sic] a health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with rule 134.600 of this title. In review of the requestor's submitted evidence of the ODG criteria for treatment of Knee conditions, it states that a TENS unit is an option for patients in a therapeutic exercise program for osteoarthritis as a treatment for pain. The Office has found that Osteoarthritis has not been accepted as a compensable injury on this claim, therefore the use of a TENS unit for the diagnosis of Knew Sprain and Tear Medical Meniscus of the Knee is outside the ODG criteria and would of needed preauthorization to substantiate the necessity of the unit. The Office has found that the requestor has failed to submit medical **based evidence** to support the medical necessity for the use of a TENS unit for the diagnosis' as billed by the requestor…"

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2010	HCPCS Code E0730-NU	$393.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. 28 Texas Administrative Code §137.100 sets out the procedures of the Treatment Guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 10, 2010

- 197 – Payment denied/reduced for absence of precertification/preauthorization.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support the TENS unit was one of the recommended treatments for the diagnosis of knee sprain and tear medial meniscus of the knee?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307. The request is eligible for review.

2. The insurance carrier denied the services in dispute using denial code 197 - "Payment denied/reduced for absence of precertification/preauthorization. Pursuant to 28 Texas Administrative Code §134.600(p)(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental) requires preauthorization. Although the amount billed by the requestor did not exceed $500 in billed charges in accordance with 28 Texas Administrative Code §137.100(e) an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   Both the requestor and insurance carrier submitted identical ODG Treatment Procedure Summaries. In review of the TENS use guidelines it is recommended as an option for patients in a therapeutic exercise program for osteoarthritis as a treatment for pain. The insurance carrier stated in their position summary that osteoarthritis has not been accepted as part of the compensable injury. Per 28 Texas Administrative Code §137.100(f) a health care provider

that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization.

3. The requestor did not obtain preauthorization for treatment that exceeded the treatment guidelines; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).